Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Texas Health of Azle

Respondent Name
Texas Mutual Insurance Co

MFDR Tracking Number
M4-14-1799-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
February 12, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Their EOB states this HCPC is not payable which must have been done in error, per the NCCI edits for a FACILITY it is payable, especially when the ER HCPC has the modifier 25 added."

Amount in Dispute: $100.86

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Review of the NCCI Edits shows that separate payment can be made for code 99281 with the appropriate modifier otherwise the Edits show the code is a component of code 90715. Review of the bill shows the failure of the facility's coder to add a modifier to code 99281. Absent such no payment is due."

Response Submitted by: Texas Mutual Insurance Co

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 8, 2013	99281	$100.86	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403, titled *Hospital Facility Fee Guideline – Outpatient*, sets out the reimbursement guidelines for facility services provided in an outpatient acute care hospital.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 435 – Per NCCI edits, the value of this procedure is included in the value of the comprehensive procedure
   - 724 – No additional payment after a reconsideration of services

Issues

1. Did the carrier support denial of the disputed service?
2. Is the requestor entitled to reimbursement?

Findings

1. The carrier denied the disputed service as, 435 – "Per NCCI edits, the value of this procedure is included in the value of the comprehensive procedure." 28 Texas Labor Code §134.403(3) states in pertinent part, "Medicare payment policy" means reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare." Review of the NCCI edits found on following CMS website, finds the following:
    a. CPT code 99281 is found to have edit with code 90471 with the following modifier indicator, (1)
    b. NCCI manual indicates, "Each NCCI edit has an assigned modifier indicator. A modifier indicator of "0" indicates that NCCI-associated modifiers cannot be used to bypass the edit. A modifier indicator of "1" indicates that NCCI-associated modifiers may be used to bypass an edit under appropriate circumstances. A modifier indicator of "9" indicates that the edit has been deleted, and the modifier indicator is not relevant."
    c. Service in dispute did not include documentation to support over-ride of edit

    The carrier's denial is supported.

2. Provisions of 28 Texas Labor Code §134.403 does not allow additional payment.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	April 30, 2014 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.